Be Smart About Your Heart
Control the ABCs of Diabetes
- A1C
- Blood Pressure
- Cholesterol

CENTRAL DISTRICT HEALTH DEPARTMENT

Check _____

Cash _____

How many hours did you fast? _____

Have we tested you before? **Y N**

CLIENT DATA FORM

SEX: ❑ Female ❑ Male

Birth Date: _____/_____/_____
month day year

NAME (print) _____ _____
LAST name *FIRST name*

ADDRESS (number / street) _____

CITY_____ STATE_____ ZIP_____ PHONE_____

YOUR AGE _____ YOUR HEIGHT _____ YOUR WEIGHT _____

DIABETES	Circle
Do you currently do some form of physical activity on a regular basis? (at least 3 times a week)	**Y N**
Does a parent, grandparent, brother, or sister have diabetes? ❑ Check box if unknown	**Y N**
Do you have diabetes?	**Y N**
If self, do you control diabetes by: Medicine: **Y N** Diet: **Y N** Exercise: **Y N**	

HEART HEALTH	Circle
Are you currently under physicians care?	**Y N**
Do you take cholesterol-lowering medication?	**Y N**
Do you take blood pressure medication?	**Y N**
Are you currently using tobacco?	**Y N**

Consent For Blood Sample:
I consent to having a blood sample drawn for the purpose to determine my blood cholesterol level. The screening will be kept confidential. (UNDER 18 a parent signature is required)

_____ _____ _____/_____/_____
Signature *Parent / Guardian* *Today's Date*

This form also available on CDHD web site:
cdhd.idaho.gov

7 . 27 . 04

_____ / _____
BP Reading